

## MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-049899

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

12379

STATE FILE NUMBER

FILED DEC 20 1963 111 XC-21 673 782

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY ST. FRANCIS	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI		Length of stay in 1b 202 DAYS	c. CITY OR TOWN FLAT RIVER
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VAH, ST. LOUIS, MO.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 219 ADAMS STREET
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM L. ROBINSON		4. DATE OF DEATH Month Day Year 12/12/63	
5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 9/11/38
9. AGE (last birthday) 25		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MECHANIC		10b. KIND OF BUSINESS OR INDUSTRY UNKNOWN	11. BIRTHPLACE (City and state or country) FLAT RIVER, MISSOURI, USA
12. CITIZEN OF WHAT COUNTRY USA		13a. FATHER'S NAME FRED ROBINSON	
13b. MOTHER'S MAIDEN NAME HAZEL AUBUCHON		14. NAME OF HUSBAND OR WIFE - - - -	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES PEACE TIME SVC.		16. SOCIAL SECURITY NO. UNKNOWN	
17. INFORMANT FRED ROBINSON (FATHER) SEE #2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO (b) Hodgkins Disease, Sarcoma Stage DUE TO (c) 201 X Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			
PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from 5/23/63 to 12/12/63 and last saw him alive on 12/12/63 Death occurred at 10:50 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Dorothy R. Silverman M.D.		22b. ADDRESS VAH, ST. LOUIS, MO.	
22c. DATE SIGNED 12/12/63		23a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial-6312-15-63	
23b. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		23c. LOCATION (City, town, or county) (State) Hester, Missouri	
24. FUNERAL DIRECTOR Caldwell Funeral Home Flat River, Mo.		25. DATE RECD. BY LOCAL REG. DEC 14 1963	
26. REGISTRAR'S SIGNATURE Rosal Smith, M.D.			

USE BLACK INK  
OR  
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF:

VS 300  
Rev. 4/59  
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JAN 7 1964

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed

*James L. Cresson*

Licensed Embalmer No. 5168

P. O. Address Millstadt, Ill.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.